



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Memorial Compounding Pharmacy

**Respondent Name**

Zurich American Insurance Company

**MFDR Tracking Number**

M4-17-2200-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

March 20, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The attached bill has been denied stating no preauthorization was obtained. Reconsiderations were submitted and never processed or denied after recon; no EOB's were generated per Bill Review internal denials. We are now requesting Medical Fee Dispute Resolution."

**Amount in Dispute:** \$1,827.99

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29 – May 31, 2016	Pharmacy Services - Compound	\$1,827.99	\$609.33

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 39 – Services denied at the time authorization/pre-certification was requested.

## Issues

1. Did Zurich American Insurance Company (Zurich) respond to the medical fee dispute?
2. Did Memorial Compounding Pharmacy (Memorial) provide documentation that it received an explanation of benefits or requested an explanation of benefits for dates of service May 16 and 31, 2016 from Zurich in accordance with 28 Texas Administrative Code §133.307?
3. Is Zurich's denial of payment for date of service April 29, 2016, supported?
4. Is Memorial entitled to reimbursement for the services in question?

## Findings

1. The Austin carrier representative for Zurich is Flahive, Ogden & Latson. Flahive, Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on March 30, 2017. 28 Texas Administrative Code §133.307 states, in relevant part:

(d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.

- (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of Zurich from Flahive, Ogden & Latson to date. The division concludes that Zurich failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Memorial is seeking reimbursement of a compound cream dispensed on May 16 and 31, 2016. 28 Texas Administrative Code §133.307(c)(2)(K) requires a request from a health care provider for medical fee dispute resolution to include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

Review of the submitted documentation finds no EOBs or convincing documentation of Zurich's receipt of a request for an EOB for the dates of service in question. Because Memorial failed to provide EOBs or convincing documentation providing evidence of insurance carrier receipt of the request for an EOB related to the service in question, no reimbursement is recommended.

3. Memorial is also seeking reimbursement for a compound dispensed on April 29, 2016. Zurich denied the compound with claim adjustment reason code 39 – "Services denied at the time authorization/pre-certification was requested." 28 Texas Administrative Code §134.530(b)(2) states that preauthorization is **only** required for:

- drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*, and any updates;
- any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*, and any updates; and
- any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

The division finds that the compound in question does not include a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. Zurich failed to articulate any arguments to support its denial for preauthorization. Therefore, the division concludes that the compound in question did not require preauthorization and Zurich's denial of this date of service for this reason is not supported.

4. 28 Texas Administrative Code §134.503 applies to the compound in question for date of service April 29, 2016, and states, in pertinent part:
- (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
- (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
    - (A) Generic drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;
    - (B) Brand name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee per prescription = reimbursement amount;
    - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
  - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    - (A) health care provider; or
    - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Reimbursement is calculated as follows:

Ingredient	NDC & Type	Price/Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Compound Fee	NA	\$15.00	1	\$15.00	\$15.00	\$15.00
Versapro Cream	38779252903 Brand Name	\$3.20	40.8 gm	$\$3.20 \times 40.8 \times 1.09 = \$142.31$	\$102.00	\$102.00
Ethoxy Diglycol	38779190301 Generic	\$0.342	4.2 gm	$\$0.342 \times 4.2 \times 1.25 = \$1.80$	\$1.44	\$1.44
Amitriptyline HCl	38779018904 Generic	\$18.24	1.8 gm	$\$18.24 \times 1.8 \times 1.25 = \$41.04$	\$31.63	\$31.63
Bupivacaine HCl	38779052405 Generic	\$45.60	1.2 gm	$\$45.60 \times 1.2 \times 1.25 = \$68.40$	\$48.02	\$48.02
Gabapentin USP	38779246109 Generic	\$59.85	3.6 gm	$\$59.85 \times 3.6 \times 1.25 = \$269.33$	\$188.10	\$188.10
Amantadine HCl	38779041105 Generic	\$24.225	3.0 gm	$\$24.225 \times 3 \times 1.25 = \$90.84$	\$38.46	\$38.46
Baclofen	38779038809 Generic	\$35.63	5.4 gm	$\$35.63 \times 5.4 \times 1.25 = \$240.50$	\$184.68	\$184.68
					Total	\$609.33

The total allowable reimbursement for the compound in dispute is \$609.33. This amount is recommended.

### **Conclusion**

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$609.33.

### **ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$609.33, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

#### **Authorized Signature**

_____	Laurie Garnes	August 18, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**